Characteristic curve analysis was used to establish accuracy, sensitivity and specificity compared to pathological stage.
Results: Of 425 patients, 83 met the inclusion criteria. Accuracy for T4 disease was 88.2% ERUS and 83.8% MRI. MRI had greater sensitivity than ERUS for nodal stage (69.2% vs 48%) but lower specificity (52.4% vs 69%). Post-chemotherapy MRI had greater accuracy (93.8%) and specificity (100%) for ypT0 disease than ERUS (84.6% and 91.7%). ERUS was more sensitive for nodal sterilisation (ypN0) than MRI (75% vs 37.8%), although accuracy was poor in both modalities (53.8% and 48.8%).
Conclusion: ERUS is a valuable adjunct to MRI in local staging of rectal cancer and may be superior in detecting T4 disease and nodal response post-radiotherapy. Restaging of rectal cancer following chemoradiation continues to be a challenging problem.

1332: COLONOSCOPY UNDER ENTONOX IS FEASIBLE AND IS ASSOCIATED WITH POTENTIAL COST SAVINGS: A REVIEW OF A DGH EXPERIENCE

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Aim: Entonox has been proposed as an alternative to intravenous sedation during colonoscopy, but is rarely used. This study aims to establish the efficacy and cost-effectiveness of Entonox as the sole analgesic during colonoscopy.
Methods: A prospectively-held database was reviewed. Practice involved offering Entonox as the sole analgesic, with provision of IV sedation and analgesia to patients who refuse or cannot complete the procedure under Entonox. Potential cost savings was calculated.
Results: The total of 322 procedures performed during 18 months' period was studied. Fifty percent attempted Entonox, whilst the rest requested IV sedation. The majority who attempted Entonox (146, 91%) completed the procedure without additional analgesia, whilst 15 (9%) required so. Average comfort score was similar in the Entonox and Sedation groups. Rate of successful caecal intubation and proportion of patients diagnosed with polyps were similar between groups. Cost savings achievable by using Entonox were calculated as £1.65/patient. In our department, this potentially amounts to £789-£1754 annually depending on the rate of Entonox uptake by patients.
Conclusions: Entonox is an effective analgesic during colonoscopy in significant proportion of patients. This practice has potential cost savings, and can be associated with quicker recovery without compromising diagnostic yield or comfort scores.

1346: DIVERTING ILEOSTOMY SITE CLOSURE HERNIATION: HOW MUCH OF A PROBLEM IS IT?

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Aims: The prevalence of abdominal wall herniation at the site of a reversed ileostomy is uncertain. This study investigated the prevalence of CT abnormalities at the site of a reversed loop ileostomy.
Methods: Data over a 5 year period was used. Cancer surveillance CT images were graded as to defined anatomical abnormalities (0-normal; I-atrophy; II-defect(s) & III-herniation).
Results: 59 patients (mean age 65 years; range: 29-79) had ileostomies closed (median time 6 months; range: 2-22). 43 underwent surveillance CTs at 1-3 years. One year after reversal, abnormalities (atrophy or defects) in the anterior abdominal wall were apparent in 37%. At 2 years, CTs in 4 patients (14%) were 're-graded'; two developed some degree of atrophy (grade 0 to I), in one a defect appeared (grade I to II) and in one an asymptomatic hernia was found (grade I to III). None of the 12 patients with serial CTs at 3 years developed changes as compared to their 2 year scan.
Conclusion: Defects in the anterior abdominal wall at the site of a closed ileostomy are not uncommon. Their frequency increases with length of follow-up but true herniation is unusual. The routine use of prophylactic mesh at ileostomy closure is unnecessary.

1381: EXPLORING THE USE OF ROUTINE BLOOD TESTS TO PREDICT PATHOLOGICAL RESPONSE TO TREATMENT IN PATIENTS RECEIVING NEOADJUVANT THERAPY FOR RECTAL CANCER

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Aims: The aim of this study is to examine the relationship between pre-neoadjuvant CRP, Albumin, Haemoglobin (Hb), neutrophil-lymphocyte ration (NLR), platelet-lymphocyte ration (PLR) and tumour regression in patients receiving neoadjuvant therapy for rectal cancer.
Methods: Patients undergoing neoadjuvant therapy for rectal cancer were studied. Radiology reports, routine blood results including CRP, Albumin, NLR, Hb, NLR, PLR were recorded. Routine Haematoxylin and Eosin stained slides were reviewed to determine the tumour regression grade (TRG).
Results: 118 patients were studied; 40% had a TRG associated with a good response, 45% had no radiological response, 42% showed downstaging and 13% showed stage progression. On Chi-squared analysis, radiological response (P=0.008), older age (P=0.010) and an elevated CRP (P=0.017) was associated with poor pathological response. Only an elevated PLR(P=0.016) was associated with poor radiological response. On DFS analysis, radiological response (P=0.007), TRG (P=0.042), raised CRP (P=0.001)andLow Hb (P=0.007) were associated with poorer survival. On multivariate survival analysis only raised CRP (Hazard Ratio 2.45 95% Confidence Interval (1.16-5.16);P=0.019) was independently associated with poorer survival.
Conclusion: This study demonstrates an association between routine blood parameters and response to therapy. Delineating this association my further support the use of these parameters in decision making on neo-adjuvant therapy.

1387: A SINGLE INSTITUTION EXPERIENCE OF ILEAL-POUCH ANAL ANASTOMOSIS

Naomi M. Fearon, Cliodhna Browne, Maria C. Whelan, Paul C. Neary. *Tallaght Hospital, Dublin, Ireland.*

Aims: The purpose of this study was to assess the outcomes in patients who have undergone laparoscopic Ileal-Pouch Anal Anastomosis (J Pouch).
Methods: A retrospective review was carried out of patients who had J pouch surgery between 2008-2013. Complications were grouped into time periods and graded according to the Clavien Dindo Classification. Functional outcomes were assessed using The Gastrointestinal Quality of Life Index and Wexner Scoring Systems.
Results: Forty two patients were identified. 20 of these underwent laparoscopic surgery. The majority were male (90%) and had a diagnosis of ulcerative colitis (95%). The median LOS for completion surgery was 6 days (3-11 days). There were no immediate complications, 20% of patients had an early complication, 15% had a late complication. There were no Grade IV or V complications, 10% were classed as Grade III, the rest were Grade I and II. Half of patients gave a Wexner score 0 indicating no faecal incontinence, 11% gave a score above 5/20. The median frequency of daily bowel movements was 5.5(1 – 12) and nocturnal was 1.5.
Conclusions: Patients who undergo laparoscopic J pouch surgery generally have good results. The complication rate compares favourably to international standards and functional outcomes are promising.

1401: PATIENTS REFERRED WITH ANAEMIA INVESTIGATED BY ENDOSCOPY: DOES ANAEMIA SUBTYPE MATTERS?

Daniel Thomas, Firas Hussain, Rajab Kerwat. *Queen May Hospital, Sidcup, Kent, UK.*

Aim: To assess if non-microcytic or non-iron deficiency anaemia has a similar cancer risk as microcytic anaemia.
Method: Eighteen-month retrospective study of all patients who had endoscopies where anaemia was mentioned as an indication within an endoscopy database at a District general hospital.
Results: 358 cases were identified, 203 females and 155 males. Age ranged from 18 to 93 years with a mean, median and mode of 67, 69 and 82 respectively. Anaemia subtypes were known for 306 patients (macrocytic-19, microcytic-138, normocytic -149). 3 patients had upper gastrointestinal cancer and 25 patients had colorectal cancer including synchronous colorectal cancers in 2 patients (1 microcytic, 1normocytic). Overall cancer risk in this study is 7.82%. Upper gastrointestinal cancer risks in patients according to anaemia subtype were macrocytic (0%), microcytic (0.7%) and normocytic (1.3%). Colorectal cancer risks in patients according to anaemia subtype were macrocytic (5.2%), microcytic (8.7%) and normocytic (6.7%).
Conclusions: Non-microcytic anaemia appears to pose a clinically important risk of cancer. Comparing microcytic to normocytic anaemia;